CALIFORNIA DEPARTMENT OF
Mental Health

APPLICATION FOR DMH CLIENT AND FAMILY MEMBER EXPERT POOL

NAME: _____ TEL.: DAY_____EVE_____

ADDRESS: _____ EMAIL: _____

1. Please check all boxes below that apply to you:

   [ ] Client [ ] Family Member of Adult [ ] Family Member of Older Adult
   [ ] Family Member of Minor [ ] Transitional Age Youth
   [ ] Client/Family Members (Not currently receiving services)

2. Are you or have you been (or the client in your family, if you are a family member) a recipient of public mental health services? [ ] Yes [ ] No

3. A. What motivated you to apply for this position? *(You may attach a separate piece of paper if needed).*

   B. What are your interests in mental health?

   C. What outcomes would you like to see as a result of your participation?

PLEASE NOTE: A lack of experience in the following areas does not necessarily disqualify you.

4. What past or current experience or expertise (paid or volunteer) would you bring to the Department of Mental Health (DMH), e.g., work tasks such as review of plans and proposals, outcome data support, review of evaluation methods and measures, and participation in specified oversight functions?

5. Please describe your experience and training with statewide mental health issues, e.g., Substance Abuse and Mental Health Services Administration (SAMHSA), Mental Health Services Act (MHSA), Recovery/Wellness, Family Programs/Family Partner Programs, etc.

6. Please list any boards, commissions, or advisory committees related to mental health on which you have served or are currently serving, e.g., the California Mental Health Planning Council, local mental health boards, mental health committees, etc.

7. The work you may do as a member of the Client and Family Member Expert Pool will require an awareness of and sensitivity to ethnicity, race, age, culture, including client and family member cultures, language, gender, sexual identity and the needs of other special populations. Please note any experience or perspective you may have which you feel would be important for us to be aware of relative to these issues.

8. Do you speak/read/write a language other than English? [ ] Yes [ ] No
   If yes, what language(s)?

   Please describe your language skill level?

Signature: _____ Date: _____

Please provide any additional information with your application, e.g., Résumé, letters of recommendation, references etc. **Please mail to:**

Cathy Bishop, Consumer and Family Liaison
Department of Mental Health
1600 9th Street, Room 250
Sacramento, CA 95814
(916) 657-5102 or FAX: (916) 654-6394

For Reviewers' Use Only

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